§ 422.10 Cost-sharing in enrollment-related costs (M+C user fee).

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that HCFA follows to determine the aggregate annual ''user fee'' to be contributed by M+C organizations and to assess the required user fees for M+C plans offered by M+C organizations.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes HCFA to charge and collect from each M+C plan offered by an M+C organization its pro rate share of fees for administering section 1851 of the Act, relating to dissemination of enrollment information; and section 4360 of the Omnibus Budget Reconciliation Act of 1990, relating to the health insurance counseling and assistance program.

(c) *Applicability.* The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees.* (1) *Timing of collection.* HCFA collects the fees over 9 consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of—

(i) The estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in paragraph (b) of this section; or

(ii) For fiscal year 2000, $100 million and for fiscal year 2001 and each succeeding year, the M+C portion (as defined in paragraph (e) of this section) of $100 million.

(e) *M+C portion.* In this section, the term ''M+C portion'' means, for a fiscal year, the ratio, as estimated by the Secretary of the average number of individuals enrolled in M+C plans during the fiscal year to the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(f) *Assessment methodology.* (1) The amount of the M+C portion of the user fee each M+C organization must pay is assessed as a percentage of the total Medicare payments to each organization. HCFA determines this percentage rate using the following formula:

A times B divided by C where—

A is the total estimated January payments to all organizations subject to the assessment;

B is the 9-month (January through September) assessment period; and

C is the total fiscal year M+C user fee assessment amount determined in accordance with paragraph (d)(2) of this section.

(2) HCFA determines each organization's pro rata share of the annual fee on the basis of the organization's calculated monthly payment amount during the 9 consecutive months beginning with January. HCFA calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in HCFA's payment system on the first day of the month.

(3) HCFA deducts the organization's fee from the amount of Federal funds otherwise payable to the organization for that month under the M+C program.

(4) If assessments reach the amount authorized for the year before the end of September, HCFA discontinues assessment.

(5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section, or the fee percentage rate specified in paragraph (f)(2), HCFA may adjust the assessment time period and the fee percentage amount.

[65 FR 40315, June 29, 2000]

Subpart B—Eligibility, Election, and Enrollment

SOURCE: 63 FR 35071, June 26, 1998, unless otherwise noted.

§ 422.50 Eligibility to elect an M+C plan.

(a) An individual is eligible to elect an M+C plan if he or she—

(1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who was enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the M+C organization as an M+C plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by the M+C organization is eligible to elect an M+C plan offered by that organization;

(3) Meets either of the following residency requirements:

(i) Resides in the service area of the M+C plan.

(ii) Resides outside of the service area of the M+C plan and is enrolled in a health plan offered by the M+C organization during the month immediately preceding the month in which the individual is entitled to both Medicare Part A and Part B, provided that an M+C organization chooses to offer this option and that HCFA determines that all applicable M+C access requirements of §422.112 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to these enrollees as to enrollees who reside in the service area;

(4) Has been a member of an Employer Group Health Plan (EGHP) that includes the elected M+C plan, even if the individual lives outside of the M+C plan service area, provided that an M+C organization chooses to offer this option and that HCFA determines that all applicable M+C access requirements at §422.12 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to all enrollees, regardless of whether they reside in the service area;

(5) Completes and signs an election form and gives information required for enrollment; and

(6) Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.

(b) An M+C eligible individual may not be enrolled in more than one M+C plan at any given time.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000]

§ 422.54 Continuation of enrollment.

(a) *Definition. Continuation area* means an additional area (outside the service area) within which the M+C organization furnishes or arranges for furnishing services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of any plan.

(b) *Basic rule.* An M+C organization may offer a continuation of enrollment option to enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the M+C organization as a continuation of enrollment area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as, driver's license, voter registration.

(c) *General requirements.* (1) An M+C organization that wishes to offer a continuation of enrollment option must meet the following requirements:

(i) Obtain HCFA's approval of the continuation area, the marketing materials that describe the option, and the M+C organization's assurances of access to services.

(ii) Describe the option(s) in the member materials it offers and make the option available to all enrollees residing in the continuation area.

(2) An enrollee who moves out of the service area into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the plan. The enrollee must make the choice of continuing enrollment in a manner specified by HCFA. If no choice is made, the enrollee must be disenrolled from the plan.

(d) *Specific requirements—*

(1) *Continuation of enrollment benefits.* The M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in §422.101(a).

(2) *Reasonable access.* The M+C organization must ensure reasonable access in the continuation area—

(i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in §422.100(b)(2), to other providers who meet the requirement in subpart E of this part; and